Medicaid Insurance Coverage in Connecticut

What is Medicaid?

Medicaid is a health insurance program for individuals and families with limited income or special needs. It was enacted in 1965 under Title XIX of the Social Security Act, and operates under federal laws and regulations that allow states discretion in the scope of coverage and eligibility standards. It is called “HUSKY Health” in Connecticut, and covers more than 600,000 state residents.

Who is covered?

HUSKY Health covers the following groups:
- HUSKY A and HUSKY B: low-income children and families who lack access to the private health insurance system mostly due to costs
- HUSKY C: low income adults living with chronic illnesses or disabilities for whom private health insurance is inadequate; AND low-income Medicare enrollees, also known as “dual eligibles,” to assist with Medicare premiums and cost-sharing and to cover key services, especially long-term care, that Medicare limits or excludes; and
- HUSKY D: low-income adults with incomes up to 133% of federal Poverty Level MED-Connect (Medicaid for Employees with Disabilities)
- Health insurance for people with disabilities who are employed and who exceed the low income limits of HUSKY C, and receive same coverage of services as regular Medicaid.

What services are covered?

The benefit package covers a broad range of medically necessary services, including physician, hospital, home health, prescription drugs, long term care, dental, and non-emergency medical transportation. Under federal law, children in HUSKY A are entitled to all mandatory and optional services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. Community mental health services include day treatment services, rehabilitative services, individual, family and group therapy. In addition, behavioral health services are managed under the Behavioral Health Partnership operated by an administrative services organization (ASO-Value Options) which coordinates care and monitors outcomes.

How is Medicaid structured?

Medicaid is financed jointly by the federal government and the states. The federal government matches state spending on Medicaid and there is no cap on funding while funding is based on actual need. Connecticut operates Medicaid through an Administrative Services Organization (ASO - Community Health Network) and person-centered medical homes (PCMH) to coordinate care. Experience with
PCMH has shown to reduce the average cost of care for participants and improve health outcomes. This is partly due to greater use of well-visits, more timely appointments and better engagement with participants.

Due to higher federal reimbursements and program reforms, it is expected that Connecticut’s Medicaid state spending levels will remain under control into the next biennium and beyond, while being able to benefit more Connecticut residents under Medicaid expansion.

Connecticut’s Department of Social Services (DSS) is pursuing additional state plan options under the Medicaid program which would allow Connecticut to cover new services for targeted populations that have been or are at risk of institutionalization or homelessness.

**Medicaid Waivers**

States can obtain federal waivers which authorize them to operate their Medicaid programs outside of federal guidelines provided they are cost neutral to the federal government. These waivers allow states, among other things, to cover non-medical services and target certain populations and regions. The most common waiver is for Home and Community Based Services under Section 1915(c) of the Social Security Act to fund alternatives to institutional placements. Connecticut has obtained waivers to serve elders, persons with developmental disabilities, mental health conditions, acquired brain injury and children with autism.

States can also obtain research and demonstration waivers (Section 1115) which allow states to demonstrate new approaches to the delivery of health care services that are intended to be cost effective and improve health outcomes.

Connecticut has submitted an application to operate a shared savings program for Medicaid beneficiaries with complex care needs, meaning that providers can share in financial savings if they reduce the total cost of care for the people they treat.

**Program Oversight**

The Medicaid Program is monitored by the Medical Assistance Program Oversight Council (MAPOC) comprised of legislators, advocates, providers and people receiving Medicaid services who meet regularly and receive reports on program developments, policies and proposed changes. The Behavioral Health Partnership has a separate oversight council (BHPOC) with similar authority for behavioral health services.

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